State of VT Buildings & General Services
Office of Workers' Compensation Claim Questionnaire

Please complete this form promptly and return it in the enclosed envelope to assure prompt handling of your claim

Name: _____ Claim #: _____ Adjuster/Assistant: _____

Division:_____Work #: _____ Supervisor: _____

Are you self-employed? YES NO Is the State of Vermont your only employer? YES NO

Additional Employer: _____ Supervisor: _____

Additional Employer Address: _____ Phone #: _____

NOTE: Please be advised that if you miss time from work due to this injury, any and all income received from a second employer or self-employment during your period of disability must be reported to your adjuster.

Describe the events that led up to your injury and how your injury occurred: _____

_____

Were there any witnesses: NO YES (If yes, name and phone #: _____

What body part(s) were injured: _____

Describe the symptoms you had as a result of the injury: _____

_____

Do you still have these symptoms: YES NO If yes, which symptoms are still present: _____

_____

List all the medical providers who have treated you for this injury or illness: _____

_____

Have you ever had any previous symptoms or treatment of the same part(s) of the body: YES NO

If yes, provide the names of the medical providers who have treated you in the past and the previous dates of treatment:

_____

I hereby affirm that the above statements are true:

_____ _____

Signature Date